casional attacks of faintness, of a swimming sensation in the head, and of a tingling in left leg up to the knee.

The apex beat was outside the nipple-line and an aortic direct murmer was present. Intelligence, memory and attention were good; he understood all questions and answered them promptly and correctly in writing, but could not utter a word. He could understand what he read, copy words and figures, write spontaneously and from dictation.

Although his general condition improved and he resumed work, loss of speech remained absolute until nine weeks after its disappearance. While at work he fell a distance of six feet, landing on his head. He was somewhat stunned, but almost immediately called his companion by name, and from that time was able to talk. The author reaches no conclusion as to the nature of the case. PATRICK.

HEMIANOPSIA IN CEREBRAL ABSCESS OF OTIC ORIGIN. Lannois and Jaboulay. Gaz. Med. de Paris, 37, 1896.

The authors report a case of cerebral abscess due to extension from an otitis purulenta, which, according to their researches, is the ninth case in literature giving right-sided hemianopsia.

Further symptoms were agraphia, alexia, optic aphasia and right-sided facial paralysis. Upon autopsy there was found diffuse encephalitis of the central lobe of the left hemisphere and at the base of the first frontal convolution; and in addition a large abscess involving the greater part of the central portion of the left occipital lobe. JELLIFFE.

EXPERIMENTS ON OPERATIVE EXPLORATION OF THE BRAIN. Payr. Centralb. für Chirurgie, No. 31, 1896.

To determine what could be learned by exploration through very narrow openings in the skull, the author performed a series of experiments upon dogs. He made use of drills 1 and 1½ to 2 mm. in diameter, with adjustable shields (to prevent sudden perforation and wounding of underlying structures), operating with all aseptic precautions. The questions which he attempted to decide were: 1. If it was possible with straight and curved exploring needles to reach collections of fluid beneath the membranes or in the brain substance. 2. If using little harpoons of special construction, particles of brain substance or membranes could be removed and examined microscopically. 3. If it could be determined whether the dura pulsated or not. For this latter purpose he used little glass tubes filled with sterilized water, and also closed tubes with end drawn fine, and bent at a right angle, to serve as indicators. The five dogs operated upon recovered promptly, and seemed to have experienced no ill results. All the questions were decided affirmatively. To determine how far he could reach with the exploring needle, he injected through the drill-hole the brain of a dog—dead from another experiment—with alcoholic methylene blue solution, and found on section that the fluid was distributed over 10 to 12 cm. of surface, and penetrated 4 to 6 cm. An autopsy made three weeks after the operation, showed healing with adhesion between dura and bone, and with but a slight depression where the brain substance had been removed by the harpoon. The opening in the bone was filled with a firm reddish-yellow mass. He does not attempt to say how far this procedure is applicable to human beings, but suggests that it may be of use in locating hemorrhages, cysts, or tumors, and obtaining specimens for microscopical examination; also for tapping the lateral ventricles. C. L. ALLEN.

POLIENCEPHALOMYELITIS.

The disease is most common in persons between 20 and 60 years of age. It is usually subacute in onset, rarely acute or insidious, at first progressing subacutely and later pursuing a chronic, stationary or varying course. Manifestations of constitutional disturbance, such as fever, headaches, vertigo, vomiting, are generally wanting throughout. In most cases the ocular muscles are first involved and in irregular order, one after the other. Ptosis may appear first on one side and then on the other and may be slight or pronounced. Then the other muscles become involved, usually in greater degree upon one side than upon the other. The fourth and sixth nerves are not spared. Diplopia is not always present; and almost never well defined strabismus. The internal ocular muscles usually escape. The disturbance of the ocular muscles generally recedes, to give place to bulbar or spinal symptoms, or they may remain in association with the latter Sometimes the disease sets in with bulbar symptoms and rarely with weakness of the muscles of the neck, trunk and extremities, advancing upward. Usually extension occurs in stages, weakness in the upper or lower extremities being suddenly added to the paralysis of the ocular muscles; or paralysis of the muscles of deglutition or the ocular muscles being added to weakness of the neck. Not rarely bulbar symptoms predominate, including weakness, fatigue, permanent or progressive paralysis of the muscles of the face, tongue, those of mastication, of deglutition; those of the œsophagus in unequal degree upon both sides. In the extremities the parts nearest the trunk are involved earlier than those at a distance; the extensors at times more than the flexors.

The tendon-reflexes, and especially the knee-jerks, are enfeebled or lost. The sensory and the sensorial functions usually remain uninvolved, as well as psychic activity and the sphincters. Fibrillary twitching is not observed. Muscular atrophy does not take place as a rule; if at all, late and in slight degree. Paralysis is the primary and the most conspicuous manifestation. The electric reactions remain unchanged or are enfeebled and in grave cases, perhaps, lost. Degenerative reactions are rare. The so-called myosthenic reaction is observed in some cases—that is the muscles respond normally to faradic currents of ordinary intensity, but to tetanizing currents the response grows gradually more and more feeble until it ceases altogether. It appears most marked when the fatigue-phenomena or voluntary innervation are quick and pronounced.

The intensity of the palsy is variable. Fatigue and recovery take place readily and quickly. The degree of fatigue does not always correspond to the degree of permanent weakness and paresis. In severe cases the patients become completely helpless. In walking, the knees may give way; or the gait may be staggering. Active exercise may be attended with an urgent sense of the need of air, from fatigue of the respiratory muscles. Not rarely sudden death occurs from paralysis of the vagus or of the diaphragm. Other dangers may arise from sudden weakness of the muscles of the pharynx and œsophagus, so that liquid diet may be necessary and regurgitation through the nares may take place. If the hands are involved there may be difficulty in carrying food to the mouth, in writing and in other manual exercises. When the eyes are used, the ptosis is aggravated and the muscles of the neck become weaker from efforts to hold the head erect. Speech becomes nasal and after a time indistinct, low and whispering. The ability to sing and to whistle is lost, and smoking becomes difficult.

A characteristic feature of the disease is the rapid recovery of strength after rest and the improvement in the morning after sleep. Remissions in the intensity of the symptoms occur from time to time and may continue for varying periods—from days even to years—and simulate perfect recovery. The progress of the disease may further be very slow and characterized by exacerbations; or the morbid process may finally cease to progress, leaving a condition of permanent weakness. Sometimes death occurs unexpectedly.

In many cases no lesion has been found after death. In one case degenerative changes were present in the medullary sheaths of the nerve-roots of the medulla oblongata. In another there was vascular dilatation, with hemorrhage and degenerative-atrophic conditions of the ganglion-cells of the central gray matter. These various lesions, however, are inconstant and inadequate to explain all of the symptoms; so that it must be assumed that there occur chemic, nutritive or toxic changes capable of disappearing and of repair without leaving evidences of their previous presence.

In an etiologic connection most of the cases reported have had some drect or indirect relation to one or another of the infectious diseases; others to over-exertion or to excessive use of alcohol or tobacco. No relation to syphilis could be established.

Subacute or chronic poliencephalomyelitis is to be distinguished from acute encephalitis by the absence of acute onset, of constitutional manifestations (fever, delirium, etc.) and other cerebral symptoms (aphasia, etc.); by its peculiar and more systematic invasion (bulbo-spinal symptoms) and its chronic, partly remitting, partly progressive course. Poliencephalomyelitis differs from acute poliencephalitis in the absence of symptoms of general disturbance (vertigo, vomiting, optic neuritis, delirium, etc.), in the less rapid course and in the presence of bulbar and spinal symptoms. From progressive bulbar paralysis it differs in the less characteristic localization and a less universal involvement of the bulbar nuclei, in its irregular, fluctuating, remitting course, in the absence of fibrillary twitching and of degenerative reactions, in the relative absence of muscular atrophy, in the presence of muscular fatigue, in the possibility of improvement, in the absence of distinctive lesions, in the early and frequent involvment of the ocular muscles and also of the neck and extremities, and in the irrregular, abrupt involvement of the entire system of bulbo-spinal nuclei. From amyotrophic lateral sclerosis it is to be differentiated by the absence of spastic manifestations and from progressive muscular atrophy by the varying course, characteristic localization, atypic distribution, unsteady progression, early participation or precedence of paralysis of bulbar nerves and of the ocular muscles. It is to be distinguished from pseudo-bulbar palsy by the mode of onset and by the presence of psychic disturbance and of hemiplegia.

In the treatment of poliencephalomyelitis drugs have proved of no service. The best results will be secured through rest and the avoidance so far as possible of muscular activity; every unnecessary fatigue should be avoided. Solid food should be interdicted and only small quantities of soft food and of liquid given at frequent intervals. In aggravated cases the administration of nutritive enemata may answer a useful purpose. Especial attention should be directed to prophylaxis, in so far as the danger of infection is always to be avoided, and should such effort prove futile the acquired disease, with its attendant intoxication, should be gotten rid of with all possible expedition. During convalescence from infectious diseases undue physical effort should be avoided and roborant treatment should be instituted.—Journal of the American Medical Association, Nov. 21, 1896. H. L. S.

CORTICAL EMBOLISM IN THE INSANE.

Tomlinson and Chilgren (Med. Record, August 1, 1896) report a case of what they term "cortical embolus (red softening)." The paper may be considered as a brilliant example of how not to report a case. Four-fifths of the contribution are devoted to an imperfect clinical report and irrelevant post-mortem details. No evidence is adduced of embolism of a single vessel and attention is called to no